Fieldhouse Care Ltd

The Chestnuts Care Home

Inspection report

72 Church Road
Normanton
West Yorkshire
WF6 2QG

Tel: 01924220019

Date of inspection visit:
15 December 2016

Date of publication:
15 February 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 15 December 2016 and was unannounced. The previous inspection was in November and December 2015 and there were breaches in the regulations, resulting in the home being placed in special measures. We noted there had been significant improvement since the last inspection and standards of care provision were much better.

The Chestnuts Care Home provides care for up to 41 people, mostly who are older people and some of whom are living with dementia. The home is situated in Normanton and is on two floors. At the time of the inspection there was a manager in place whose application to register with the Care Quality Commission was in progress, awaiting completion. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a homely, friendly environment in which people said they felt happy and safe. There were clearly noticeable improvements since the last inspection in the overall quality of the provision.

Risk assessments had improved since the last inspection in relation to people's individual safety needs, although checks were not as robust for equipment and premises, such as bedrails and the hot water supply. There was more information available to staff with regard to moving and handling people safely and staff mostly followed safe practice, with the exception of one observed incident. We found there was improved practice around accidents and incidents, with a more proactive approach to preventing falls. There was evidence of ongoing refurbishment and we noted this was in progress, although there were odours in some areas.

Staff training had been completed to improve staff knowledge of the Mental Capacity Act (MCA) and the deprivation of liberty safeguards (DoLS) and there was clear recording where a person may lack capacity, although it was not always evident who had power of attorney to lawfully make decisions on behalf of people who were no longer to make these decisions or consent to care.

People had good opportunities for regular snacks and drinks, with variety and choice available. Where there were gaps in the recording of people's food and fluid intake, this was identified through the management audit process.

Staff engaged positively with people and there were sensitive interactions which showed care was person centred and caring. Care plans were detailed although not always updated promptly. People were purposefully engaged with meaningful activities, although there was more limited interaction fro those people who remained in bed. People in bed could not always make their need for staff attention known and they could not always be heard if they were unable to use their call alarm.

People and relatives knew how to complain and said they found management to be approachable. Complaints and compliments were recorded and there was evidence of action taken where necessary.

Leadership of the home was much more clearly defined than at the last inspection with direction for staff to be supported in their roles and responsibilities. Auditing and monitoring the quality of the provision had improved, although there were some areas that lacked rigour, such as daily checks. There was improved partnership working with other professionals to support people's health and wellbeing. The home was forging links with the Vanguard initiative in Wakefield. This initiative has been drawn up to improve care standards in care homes by a range of measures, one being increased access to the wider multidisciplinary team and enhanced pathways to primary care.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were some gaps in the assessment of risks within the home to ensure people's safety, such as bed rails, the call bell system and the water supply. The manager sent us a prompt response immediately following the inspection to show how these were being addressed.

Staffing levels were appropriate to meet people's needs and staff's knowledge had improved with regard to safeguarding people and moving and handling people safely in line with their needs.

Recruitment procedures were not always robust.

Is the service effective?

Good

The service was effective.

Staff had completed training and felt supported in their role, through supervision and effective teamwork.

Staff had an improved understanding of the legislation around mental capacity and the impact upon people's care.

Mealtimes were pleasant, sociable and enjoyable, with many opportunities for people's choices with regard to eating and drinking.

Is the service caring?

Good

The service was caring.

There were good relationships between staff and people who lived in the home and there was a welcoming and homely environment.

People's privacy and dignity was respected.

Staff were sensitive and compassionate regarding end of life care.

Is the service responsive?

Good

The service was responsive.

People engaged in a variety of meaningful activities and staff understood people's individual needs.

Care was person-centred and care records were more detailed and being further developed, although daily records were not always completely in a timely way.

Complaints were recorded in detail and people understood how to raise concerns should they need to.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements since the last inspection were clearly evident and the provider was continuing to develop the quality of the service.

There were clear lines of accountability and responsibility. Audits and quality monitoring had improved, although there were still some gaps in how rigorously these were carried out.

The provider had a positive approach to working with others to enable improvements to be sustained.

The Chestnuts Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 December 2016 and was unannounced. There were two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at notifications, the provider information return (PIR) and liaised with other professionals with knowledge of the service, such as those in the local authority. During the inspection we spoke with 20 people who used the service, four of their relatives and friends and four staff. We observed care and reviewed five people's care records as well as documentation to show how the service was run.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at The Chestnuts. One person said: "I do feel safe, I really do". Another person said: "Well I'm sure about that, they are good about keeping me safe". One relative said they felt assured their family member was safe in the care of the home.

Staff understood the steps to follow to ensure people were protected from harm and they knew the safeguarding and whistleblowing procedures. They told us how they identified the signs of abuse and said how they would respond to any such concerns or allegations. One member of staff said: "We keep people safe by knowing what their needs are and we follow policies and procedures". A member of ancillary staff said if they saw any poor or unsafe practice they would report this to the management team. We saw the whistleblowing policy highlighted what staff should do in the event of a concern or allegation and this policy was regularly reviewed.

Accidents and incidents were monitored and the manager had identified trends and patterns in falls, and taken measures to prevent further occurrences through the addition of staff at a peak time. The noticeboard displayed a Vanguard newsletter with 'top tips for preventing falls' to help inform staff and others of preventative measures to keep people safe. We noted that where some incident reports involved equipment, this was not recorded in sufficient depth to show the equipment safety was reviewed, although it was clear what had been done to support the person involved. For example, records showed one person had put their legs through the bedrails as the protective bumper had not been in place and this had resulted in a skin tear. Whilst there was clear recording of the treatment of the skin tear, there was no information on the accident/incident form about what had been done to review the equipment, although the person's care plan did show equipment had been considered.

The manager told us they were confident systems and processes had been improved since the last inspection to ensure people's safety. We found high priority had been given to meeting the requirements of the regulations in relation to safe care and treatment. For example, individual risk assessments in people's care plans were more detailed; we saw people's care records for moving and handling identified the equipment, such as the hoist and sling size needed and there were very detailed plans on how each person needed assistance, such as to get into a chair.

We observed many examples of good practice with moving and handling; staff supported people properly with clear explanations and reassurance so people felt safe. Staff told us they looked at people's moving and handling care plan to know how they needed to be supported, and where equipment was needed for this there were clear instructions in care records which staff said they understood. However, we observed a manoeuvre in which a member of staff handled a person without using the required technique or equipment and this could have caused harm. We informed the management team and made a safeguarding referral for this person.

We discussed whether some people had specialist seating as we saw one person who sat awkwardly in the dining room and their posture was not fully supported. The manager told us specialist bespoke seating was

not available for this person but they would give further consideration how people's seating needs could be addressed on an individual basis.

There were safety checks in relation to the home, but these were not always robust enough to demonstrate safety aspects had been fully considered and risks mitigated. For example, the provider was unable to show us water checks had been carried out in relation to the risk of legionella. We found the hot water supply was variable throughout the building and from some of the taps it did not run hotter than tepid. We discussed this with the provider and referred our concerns to the Environmental Health Officer, who made a visit and requested the provider take the necessary steps to ensure the water supply was safe. Some of the manager's safety checks were tick-lists, which did not show the extent or details of the checks made. We noted some bedrails had no protective bumpers in use and it was unclear from the daily checklists whether this had been identified. We noticed a potential choking hazard in some people's rooms where powdered drinks thickener was not securely stored and discussed this with the manager who agreed to address this matter.

We saw the safety of the nurse call system had not been assessed for individuals. For example, one person had their call bell cord placed out of reach and when we discussed this with staff they explained this was because the person had previously wrapped the cord around themselves and it was considered a hazard. We saw another person who had the cord near to their face whilst in bed and the safety of this had not been fully considered for this person, or for others for whom the cords may become a tangle hazard.

We found the provider was progressing through a programme of refurbishment in the home and had addressed many of the areas of concern highlighted at the previous inspection. For example, bathrooms had been refurbished as had many of the bedrooms and there was evidence of ongoing decoration and improvement to the premises. The provider told us there had been refurbishment of the central heating system and an additional boiler. We looked at the provider's business objectives action plan which timetabled the work planned and done, with completion dates.

We noted the gas cooker had been issued with a warning/advisory notice from the engineer and we discussed this with the provider who stated this was advice only. The provider showed us the engineer's record which stated 'advice only' and stated this would be attended to as part of the ongoing refurbishment plan, but they were satisfied the appliance was safe.

The provider's fire safety risk assessment had been revised and staff understood what to do in the event of such an emergency and people had individual personal emergency evacuation plans (PEEPs) with key information as to how they should be supported.

We looked at three staff records and found applicants' employment history had not been sufficiently explored or recorded to evidence recruitment was robust. For example, for dates of previous employment applicants' stated the years this covered rather than months and years, which meant there were possible gaps unaccounted for. In one staff file we looked at there was only one reference recorded, although the provider told us two had been obtained. There was no record of the interview discussion in one staff file we reviewed.

The staffing rota showed staffing levels were appropriate for people's needs. We saw there were enough staff to be able to respond promptly to support people on the whole, although where people were in bed and could not operate their call bell, they were not always able to be heard. One person who was upstairs told us they liked to be downstairs but had to wait for staff to assist them. They said they thought people upstairs got 'less attention' and said they waited a long time for staff 'and then three come at once, like buses'. We saw staff made checks of people in their own rooms, but the frequency of this was not always

consistent. Where people needed regular repositioning, we saw staff paid attention to this and the recorded frequency of these checks showed this was managed in line with people's care needs. Where hourly checks were needed by some people, we found there were some gaps in recording of these.

Many people who used the service, their relatives and staff reported they had no concerns about the levels of staffing available since the last inspection. One person said: "There's always someone there for me" and another said: "That's the thing, staff are right where I need them". One member of staff said: "The staffing ratios are definitely better". The manager told us an additional shift had recently been introduced, the twilight shift, to support people during a busy period of the day and this was proving to be successful. One relative said they had no real concerns about staffing levels but added, "To be honest, sometimes there are not enough staff but you've got to see it from both sides". Another relative said: "I never have a problem finding staff when I visit".

We looked at the systems in place for the receipt, storage and administration of medicines in the home. We saw medicines were stored appropriately and safely; staff kept the keys to medicine storage safely and understood their responsibilities.

Staff who supported people with their medicines did so patiently and carefully, offering explanations about what the medicines were for and checking whether anybody needed any pain relief. We saw staff stayed with people until they had taken their medicine and they reassured people they could take their time.

Records were updated accurately as medicines were given and staff worked methodically whilst still giving people the individual time they needed. Staff communicated well with one another when topical creams were applied and discussed people's skin integrity to ensure the correct care was being given. However, where tissue viability nurses (TVNs) were involved in people's care we saw detailed notes which showed TVN instructions had been followed, but there was no specific wound care plan in place to show the progress in wound management.

The home was visibly clean with few malodours, although in areas where refurbishment was yet to be carried out, some odours lingered. We saw staff appropriately used personal protective equipment (PPE) and engaged in practices to minimise the spread of infection. Records showed good infection control practice had been discussed with staff, such as the company's bare below the elbow policy.

Good

Is the service effective?

Our findings

People and relatives told us staff had the necessary skills for their work. One person said: "They know all about me and what I like. I think they can do their jobs". One relative said: "Staff are knowledgeable, they get training".

We saw from the training matrix, staff had received regular training in a range of relevant topics to enable them to carry out their role effectively. New staff worked towards the Care Certificate and had a thorough induction. Staff told us they felt supported to undertake further training to enhance their role and they thought the training was meaningful. The management team were working with local training initiatives, such as the React to Red pressure ulcer prevention campaign and they were in the process of upskilling staff with this information.

Staff told us they received regular supervision to discuss their work and their development. We saw records of individual and group supervision in which training and practice issues, such as fire drills and hand hygiene were discussed with staff. One member of staff said: "I feel very supported and listened to". The manager told us they aimed to carry out four to six supervisions a year and one annual appraisal. Staff told us they had competency checks as part of their work to ensure their ability in their role.

Staff worked well together. They remarked there was good team work and said they knew each other's strengths and weaknesses. One member of staff gave an example of how a colleague could not make beds so the rest of the team made up for this. Other staff said team work was strong in the home. One staff member said: "We are a good bunch".

We saw the morning handover and this was carried out privately and was detailed enough to ensure the receiving shift had all the necessary information from the staff going off duty, in order to care for people's needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The manager showed us a clear matrix which

detailed the people for whom DoLS applications had been sent, approved, expiry date and any special requirements.

Staff we spoke with understood the legislation around people's mental capacity and human rights. Since the last inspection staff had received training and this meant they had a better understanding of people's needs and how they may be supported if they lacked capacity to make specific decisions. Care records did not always show where best interest decisions had been made with people and other relevant parties, for specific decisions. For example, we saw an entry on one person's care record that said their GP had requested for medicines to be given covertly, although the best interest decision making process was not clearly shown. We saw the faxed agreement from the GP, but this did not state which medicine was to be given covertly or how this should be disguised. We discussed this with the manager who agreed to ensure this process was properly documented. It was not clear where people's family had power of attorney to make decisions on their behalf. This had already been identified by the management team and a recent newsletter to families had requested they provide proof of this authorisation.

We heard staff asked people's consent before carrying out care tasks and they encouraged people to make decisions for themselves within the routine of the day, such as where they wanted to sit and what they wanted to eat or drink. Staff chatted with people about their individual preferences and people told us they made decisions about their care and support. One person said: "They always ask, it's up to me".

People told us they enjoyed the meals at The Chestnuts and the quality of the food was good. One person described their breakfast as "10/10" and said they had "been given the lot" meaning they had been given a cooked breakfast. One person said they really enjoyed poached eggs and we saw this was offered. Another person said: "The food is good" and another person told us: "There's one thing I do know, the food here is great". The chef had an understanding of people's individual dietary needs and their personal preferences. Where people needed particular diets, such as a diabetic diet or additional calories, this was known and provided for.

We saw mealtimes were sociable occasions and people chatted together as they ate. People were offered support individually where necessary and staff interaction was engaging and person centred. Choices were promoted well and people were offered alternative choices if they did not want what was on the menu. We saw the food service was efficient and people did not have to wait very long to be served their meal. Where people needed encouragement staff did this in a respectful way, without compromising their dignity. Where some people required an adapted plate to help promote independence this was provided.

We saw people had frequent opportunities for drinks and snacks as well as the meals provided. Where some people required thickener in their drinks, this was stored in their rooms, however, we discussed with the manager about storing this more securely due to it presenting a choking hazard in its powdered form.

Staff told us where people were on end of life care they could have 'whatever they fancy' for meals and there were no limits to the choices they could make at any time.
We saw the home had been awarded a five star food hygiene rating from the local authority. The dining experience for people had been given management focus and the manager gave feedback to staff about observations they had made during mealtimes. The director remarked the home had made real improvements in the meals at The Chestnuts since the last inspection.

Food and fluid records were in place although there were gaps in the recording of people's intake. This had already been highlighted through the management audit processes and the manager told us they were working to improve this, although felt it was more a matter for improved recording as they were confident

good practice was in place. People's dietary needs were recorded on their care plans, along with appropriate risk assessments to support their nutrition and hydration.

We saw evidence in people's care records of referrals to other professionals for additional advice and support where necessary such as GPs, district nurses, chiropodists and opticians. The home was forging links with the Vanguard initiative in Wakefield. This initiative has been drawn up to improve care standards in care homes by a range of measures, one being increased access to the wider multidisciplinary team and enhanced pathways to primary care.

Good

Is the service caring?

Our findings

The people we spoke with said the staff were caring and they felt happy and settled. One person said: "It's alright cos they are kind".

The relatives we spoke with said the staff were caring. One relative told us their family member's dignity and privacy were respected. They said: "They [staff] close the door for privacy if they're changing". One relative said: "The atmosphere depends on how the residents are feeling. Sometimes the girls are a bit sharp with people but not with my [family member]".

The Chestnuts had a friendly, homely atmosphere and we saw people were happy and content. We observed plenty of kind, caring and patient interaction between staff and people and there was appropriate banter and humour exchanged. One person said: "We like a laugh, makes the day brighter". We saw one person initiated a hug with a member of staff and said: "I love you", to which the staff member reciprocated warmly. Another person told us: "They're so caring, they're like my family".

People's care records contained information about their cultural and spiritual needs as well as their rights to be empowered and independent in their lives. It was evident through discussions with staff they knew each person well and this enabled the care provided to be meaningful and based upon their individual needs. People's rooms were personalised with items that were meaningful to them, such as family photographs.

Staff were discreet when discussing people's information and documents were kept securely out of view. Staff were mindful of people's privacy and dignity; they supported people to be appropriately dressed and knocked on doors before entering people's rooms. Where people were in bed with their doors open, we saw this was documented on their record as being their own choice. One person in their room told us: "I like to see what's going on, I don't necessarily want to be out there, just to see who's passing by".

The manager was passionate about people having a positive experience at the end of their life, with practice that was sensitive and personalised to people's needs. One relative told us their family member's wishes for end of life care had been discussed with the home and relevant professionals and they were confident staff would meet their needs appropriately at such time. We saw documented end of life care plans were in place but were generic in format, not person centred. Staff had completed end of life training since the last inspection which helped them to further understand the needs of people and their families.

Good

Is the service responsive?

Our findings

One person told us they 'weren't bothered' about going downstairs and they preferred to remain in their upstairs room. They said: "The staff are marvellous. They are good to me". One relative told us: "We chose this place specifically. I live and work in the area. Staff care is great and [my family member's] family were in here".

One member of staff told us: "There's more emphasis on person-centred care. The staff know people better as individuals". Staff we spoke with all said they would be happy for a relative of theirs to live at The Chestnuts. One member of staff told us they provided care for people as though they were their own relatives.

Staff responded promptly to meet people's needs when people asked for staff attention. Not all people were able to summon attention, for example, if they had no access to their call bells and could not be heard. We saw on one person's care record, their call bell was a hazard to them and a bell was to be put in place. This was noted in September 2016, but the bell was still not in place at the time of the inspection. We discussed this with the manager who said they would give this matter their prompt attention to ensure the person was able to summon help.

We saw people's names were being put on their doors with discreet coded symbols to confidentially identify any particular needs they may have.
We spoke with the activities coordinator. They were enthusiastic and spoke about some of the activities people had engaged with or ideas for future ones. For example, they spoke about creating a sensory room and discussed people's individual memory books and their involvement in the choir. They gave an example of how they received good feedback, such as when a relative told them their family member 'had really opened up and expressed how [they] felt after singing' and said they 'could remember the words to songs much better than other things'.

Many people said they had enough to do. One person said the library service came round and they had chosen a large print book. They told us "The activities lady bobs in a couple of times a week". Another person said activities staff came and played dominoes and cards. One relative said: "The activities woman comes in regularly".
One member of staff spoke with us about activities and said: "It's the best it's been in a while". The activities coordinator said they tried to visit people in their rooms as much as possible. We saw care staff spent time chatting to people about what mattered to them, such as their family and friends. One member of staff spoke about a person's grandchild's graduation and it was evident staff knew people and their individual circumstances well. Another member of staff chatted with a person about their favourite film star as they watched the film.

We saw the 'residents, family and friends' newsletter gave useful information about forthcoming events, such as the Christmas festivities. There were links with groups in the community, such as children from a local nursery and a school who came along to sing. Relatives we spoke with said they felt involved and

informed about what was taking place in the home and the care of their family members. We heard a member of staff giving a friendly and reassuring update to a person's relative on phone and we saw there was open communication between staff and relatives when they visited. We saw there was a forthcoming residents meeting, although not all people been to residents meetings or knew about them. One relative said: "They let us know when letter goes up in the foyer. They are useful to get an update", but another said: "If they have them, I don't know about them". One relative said: "I speak to the staff on a regular basis".

We looked at five care records and saw care plans were detailed, although not always updated. Where people's care needs changed significantly, new information was added to the original care plan, rather than writing a new care plan that was reflective of the person's needs and this meant the most up to date information was not always apparent.

Daily records contained key information about how each person had spent their day and staff used quiet times of day to update these. Staff we spoke with said they tried to ensure information was as up to date as possible.

We noted some personal life history information about people was sparsely completed and the manager told us this was being addressed. The manager told us care records were being revised and a one page profile was being put in place with key information for staff to see at a glance what people's needs were, as well as the more detailed information within.

People, their relatives and visitors told us they knew how to complain if they were unhappy with any aspect of the service. One person said they knew the owner by name and would approach them or a nurse if they were not happy with anything. People said staff were approachable and they felt confident to raise any matters. One person said if they had an issue there was no problem discussing this and they would go to the manager. They told us: "If you tell them [the staff] I want [manager] then I will get them, if anything goes wrong I can talk and they listen to me. We talk it over with a carer or a nurse".

We saw complaints were recorded in detail and there was information about action taken to ensure matters were satisfactorily resolved. The provider had carried out a detailed investigation into a recent whistleblowing complaint and recorded their findings in detail. They told us whistleblowing was encouraged where staff found there to be poor practice. Where compliments were received these were shared with staff.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with and their relatives said the home was well managed. One person who had lived in the home for two years said they had seen improvements in how things were run. People and relatives said they could approach the manager at any time to speak with them, although one person we spoke with and their relative did not know who the manager was.

We saw the manager was visible in the service and had practical involvement in people's care, working alongside the staff team at times. The manager told us they had an open door policy and we saw this was so, with the office door closed only when absolutely necessary.

The manager had been in post approximately 12 months and their registration with CQC was in progress. The manager was visible in the service and had an improving overview of the quality of the service delivery. Staff spoke highly of the management team and valued the way the service was run. Comments from staff included: "[Manager] is passionate and we need that"; "[Manager] is honest about where we are and where we go"; "There's always an opportunity to bring things to [manager's or assistant manager's] attention" and "We're always discussing with [assistant manager] how to make things better for people". This showed there was a clear management structure and direction for staff.

We found the management team had taken positive steps to improve the culture in the home and encourage communication. For example, the director explained to the whole staff team the inspectors were on site and encouraged them to speak and share information in an open and transparent way. We were told staff ideas were listened to and valued. For example, one such idea to introduce 'twilight' staff had been implemented. One member of staff told us: "Culture? It's on a journey, the home. It's fluid as its being challenged all the time. We're constantly trying to make things better".

We saw there were improved systems and processes in place to assess and monitor the quality of the provision since the last inspection. It was evident the manager was making frequent quality checks within the home and there were more robust audits recorded, with action plans and timescales where issues had been identified. However, some of the checks lacked rigour and did not always show how thoroughly some aspects of care and service delivery had been scrutinised. There were gaps in the recording of some checks, such as the management daily checks. For example, there were only 15 daily checks recorded for September 2016, 11 for October 2016 and 13 for November 2016.

We saw some audits accurately identified areas to improve, such as gaps in recording within people's care records and loose sheets in files. Premises and equipment checks were carried out monthly and there was manager oversight of infection control within the home. Statutory notifications had been made appropriately to CQC and the provider was aware of the requirements of registration.

We looked at the home's quality assurance report for 2016 which asked service users, relatives, visitors, stakeholders and professionals their views on the quality of the service and there were positive comments made as well as suggestions for improvement. The provider made the results from this available to people

and emphasised the intention to communicate openly, with information shared about the previous inspection and the improvements made since then.

We noted significant improvements in the leadership and management of the home since the last inspection, with evidence of more cohesive working, in the home itself and with others in support of securing positive changes, such as local authority partners and the Vanguard team. The provider had given clear focus to addressing the issues highlighted through the previous inspection, and although it was too soon to assess at this inspection whether the improvements made would be sustained, there was a real commitment and motivation from the provider, managers and staff to continue to improve.